Part B: Health Care Provider Certification

All information must be filled out.

Please note the following licensed health care professionals are authorized to fill out the application:

- Physician (MD or DO)
- Psychiatrist
- Physical Therapist
- Registered Nurse
- Ophthalmologist
- Occupational Therapist
- Psychologist
- Optometrist (visual disabilities only)
- Other licensed provider familiar with the applicant's condition

Your patient _____ has requested eligibility for MTS Access Paratransit Service. MTS Access is a door-to-door, shared ride paratransit service for people whose disabilities or health conditions prevent them from riding the fixed route accessible transportation system all, or part of the time. As the applicant's healthcare provider, you are uniquely qualified to clarify the applicant's **functional abilities and limitations** to ride the MTS fixed route bus and light rail trolley systems. In order to determine this applicant's functional abilities, we require you, the healthcare provider, to complete and certify all of the following sections. Please detail how the applicant's disability(ies) or health condition(s) impact his or her ability to board, navigate, and travel independently on the accessible fixed route system. Please be as specific as possible.

Per the Federal Transit Administration (FTA), eligibility for complimentary paratransit is directly related to the functional ability of individuals with disability to use fixed route transit services. Concerns such as diagnosis, age, distance to bus stop, lack of bus service, overcrowded buses or trolleys, inability to drive, personal finances, inconvenience, and/or discomfort are not the basis of MTS Access eligibility determination.

Please be advised that all MTS fixed route buses and light rail trolleys are equipped with ADA accessible features, such as low floor buses, lifts/ramps, audio announcements, designated priority seating areas for people with disabilities, enhanced signage, kneeling buses, and hand rails.

MTS also provides a Reduced Fare Program for Seniors, Disabled, and people on Medicare (SDM Program). This fixed route program provides discounted fares and is the primary program used by most customers with disabilities in San Diego. Eligible customers can travel on accessible fixed route and light rail trolley at 68% reduced fare on monthly passes. This program is available for people with disabilities who are able to use the bus and light rail trolley systems as their primary travel option.

The information shared will be protected per the requirements identified in the Health Insurance Portability and Accountability Act (HIPAA) and your patient/client has agreed in the release of information. Your patient/client has also authorized the release of further information as needed.

Metropolitan Transit System

Part B: Health Care Provider Certification

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All pages of this form must be completed by a licensed health care professional. An incomplete application will be returned to the applicant and may delay processing. ***Every question must be answered and be legible.***

Health Care Provider (please print): _____

Institution/Facility/Agency Name: _____

License Number: _____ State Issued: _____

Specialization: _____

Street Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Email Address: _____

1. Written diagnosis(es) and ICD-9CM and/or DSM Code(s): _____

_____

2. How long have you been treating the patient? _____

3. When was the last time you saw the patient? _____

4. What is the expected duration of the disability? ☐ Short Term ☐ Long Term

   Short Term: Conditions lasting at least 90 days but are likely to improve within one year

   Long Term: Conditions with absolutely little expectation of improvement

5. In your opinion, does this applicant's disability(ies) prevent him or her from independently using the accessible MTS fixed route bus or light rail trolley service (excludes MTS Access ADA paratransit?

   ☐ Yes ☐ No

6. If yes, explain how the disability or health condition impacts the applicant's ability to travel independently on the accessible MTS fixed route bus or light rail trolley service.

_____

_____

_____

_____

_____

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7. Does the applicant require any of the following mobility aids/devices (check all that apply):

☐ Powered/Electric Wheelchair	☐ Manual Wheelchair	☐ Powered Scooter
☐ Walker	☐ Cane	☐ Crutches
☐ Brace	☐ Prosthesis	☐ Portable Oxygen in Cart
Type of Brace: _____	☐ Communication Board	☐ Portable Oxygen in Bag
☐ White Cane	☐ Service Animal	☐ None
☐ Other: _____		

8. If this applicant is currently on medication(s), will the side effects significantly reduce or hinder his/her ability to independently ride the accessible MTS fixed route bus or light rail trolley service?

☐ Yes ☐ No ☐ N/A

9. If you selected yes, please explain how the side effects would hinder their ability to use the accessible MTS fixed route bus or light rail trolley service:

_____

_____

_____

_____

For questions 10-22, select Yes (Y), No (N), or Sometimes (S). If you answer Yes or Sometimes to questions 10-21, elaborate on how it prevents the applicant from using accessible MTS fixed route bus or trolley service (excludes MTS Access ADA paratransit):

10. Would temperature extremes affect this applicant's ability to ride transit? ☐ Y ☐ N ☐ S

Please Explain: _____

11. Would rain affect this applicant's ability to ride transit? ☐ Y ☐ N ☐ S

Please Explain: _____

12. Would poor air quality affect this applicant's ability to ride transit? ☐ Y ☐ N ☐ S

Please Explain: _____

13. Does this applicant have any challenges with balance? ☐ Y ☐ N ☐ S

Please Explain: _____

14. Does this applicant have any challenges with memory? ☐ Y ☐ N ☐ S

Please Explain: _____

Part B: Health Care Provider Certification

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15. Does this applicant have any challenges with breathing? ☐ Y ☐ N ☐ S
Please Explain: _____

16. Does this applicant have any challenges with strength and endurance? ☐ Y ☐ N ☐ S
Please Explain: _____

17. Does this applicant have any challenges with ambulating on hills? ☐ Y ☐ N ☐ S
Please Explain: _____

18. Are there any visual impairments has that would affect this applicant's ability to ride transit? ☐ Y ☐ N ☐ S
Please Explain: _____

19. Are there any hearing impairments that would affect this applicant's ability to ride transit? ☐ Y ☐ N ☐ S
Please Explain: _____

20. Does this applicant exhibit any inappropriate social behaviors? ☐ Y ☐ N ☐ S
Please Explain: _____

21. Do you have safety concerns for this applicant in using a bus or light rail trolley by themselves? ☐ Y ☐ N ☐ S
Please Explain: _____

22. Does this applicant require a Personal Care Attendant when traveling? ☐ Y ☐ N ☐ S
Please Explain: _____

23. In your medical opinion, what other factors related to the applicant's disability(ies) affect his/her ability to ride the accessible MTS bus and light rail trolley service?

_____

_____

_____

_____

_____

_____

_____

Part B: Health Care Provider Certification

All information must be filled out.

Certification

*Part B: Health Care Provider Certification must be signed and dated **within 60 days** of the in-person assessment.*

I certify that I am legally licensed and am currently treating _____. The above information I have provided hereto is a fair representation of this applicant's disability(ies) or health condition(s) and is true and correct under penalty of perjury according to the laws of the State of California. I understand the information provided will be used for the sole purpose of determining the applicant's eligibility for paratransit service. I also agree that MTS and its eligibility contractor may contact me for clarification of any information I have provided and that I will reply with good faith. **I understand the information contained herein is true and correct to the best of my knowledge and ability. Any falsification could result in the client's loss of paratransit service.**

Signature: _____ Date: _____

Please make a copy for your file